STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G172	A. BUILDING _____ B. WING _____	06/29/2007

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D C HEALTH CARE	903 14TH STREET, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 28, 2007 through June 29, 2007. The survey was initiated using the fundamental survey process; however, as a result of the review of unusual incident reports and interviews, it was decided to extend the survey process in the area of Client Protections. A random sample of three clients was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home and two day programs, and interviews with clients, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	W 000	2007 JUL 20 A 11:33 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of three clients in the sample. (Client #3) The finding includes: Observation at the day program on June 28, 2007 at approximately 1:10 PM revealed that Client #3 was participating in a functional communication program identifying twenty community survival signs. Further observation revealed that Client #3 was able to identify nineteen out of twenty community survival signs independently.	W 120	pg # 1 W 120 QMRP met with day program staff on June 29, 2007 and July 12, 2007 to monitor Client # 3's progress in reference to his excessive sleeping. The day program agreed to add alternative vocational tasks, so that there is variety in activities, which will encourage him to be alert at al times. QMRP will continue to monitor the day program on a weekly basis. (See attachment A).	6/29/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gyney Stephen — TITLE: President — (X6) DATE: 7/17/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 Interview with the staff of the day program on June 28, 2007 at approximately 1:30 PM, revealed that Client #3 is not often able to complete many of his janitorial training tasks because of his excessive sleeping. Further interview revealed that in early June, the facility's Qualified Mental Retardation Professional (QMRP) was verbally made aware that Client #3 was sleeping excessively while at the day program. Review of day program progress notes dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 1:55PM revealed entires on each day that Client #3 was observed sleeping and was unable to complete his training program. Further review of the Day Program Director's progress note dated June 5, 2007 on June 29, 2007 at approximately 11:30AM at the facility revealed "the days [Client #3] didn't perform a task was because he was either trying to sleep or a different task was performed". There was no documented evidence to substantiate that during the month of May the day program made the facility staff aware that the client was sleeping excessively.	W 120		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for three of three clients in the sample. (Client #1,#2 and #3)	W 159		

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W 159	Continued From page 2 The findings include: 1. Cross refer to W120. The QMRP failed to inform Client #3's Inter-Disciplinary Team (IDT) that he was sleeping excessively in the day program as evidenced by: Observation of evening medication administration on June 28, 2007 at approximately 6:30PM revealed that Client #3 was administered Clonidine HCL 0.1mg by mouth for hypertension. Review of the medical assessment dated August 14, 2006 on June 29,2007 at approximately 1:40PM revealed that Client #3 has a diagnosis of hypertension and is prescribed Clonidine HCL 0.1mg by mouth for twice a day for blood pressure management. Interview with the License Practical Nurse (LPN) on June 28, 2007 at approximately 6:34PM revealed that Client #3 is prescribed Clonidine HCL 0.1mg by mouth for hypertension twice a day and possible medication side effects included drowsiness, sedation and insomnia. Interview with the staff of the day program on June 28, 2007 at approximately 1:30 PM, revealed that Client #3 is not able to complete many of his janitorial training tasks because of his excessive sleepiness during the day. Further interview revealed that in early June, the facility's QMRP was verbally made aware that Client #3 was sleeping excessively while at the day program. Interview with the QMRP on June 28, 2007 at approximately 7:30 PM revealed that she was made aware on June 1, 2007 by the day program staff that Client #3 had fallen asleep during training. Further interview revealed that she did not make the IDT aware that Client #3 was sleeping excessively at the day program and was unable to complete his janitorial training tasks. Review of day program progress notes	W 159 pg # 3 W 159	A meeting is scheduled for July 24, 2007 with Client # 3's Inter-Disciplinary Team (IDT) to address the excessive sleeping at the day program and necessary program revisions will be made. Mean while, the day program agreed to add alternative vocational tasks to keep him alert. Client # 3 has been scheduled for Renal appointment on 09/12/07 and Urology appointment on 07/25/07. At that point an evaluation will be made in reference to his current medication. (See attachment B & C).	7/25/07 9/12/07

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W 159	Continued From page 3 dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 1:55 PM revealed entires on each day that Client #3 was observed sleeping and was unable to complete his training program. Further review of the Day Program Director's progress note dated June 5, 2007 on June 29, 2007 at approximately 11:30AM at the facility revealed " the days [Client #3] didn't perform a task was because he was either trying to sleep or a different task was performed". Review of Client #3's sleep logs dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 10:55AM revealed entires on each day that Client #3 goes to bed at 10:00 PM and is generally awake at 10:30 PM, 12:30AM, 2:30AM and 4:30AM. Interview with the Program Director on June 29, 2007 at approximately 10:59 AM revealed that Client #3 possibly was toileted during those hours at night. There was no evidence that the IDT was made aware that the client was sleeping excessively at the day program and was unable to complete his janitorial training tasks. 2. The QMRP failed to ensure that all staff had been effectively trained to monitor/document the food intake of Client #1 as evidenced by: Dinner observation on June 28, 2007 at approximately 5:45 PM revealed that Client #1 was self- feeding with stand by assistance to hold a built-up spoon to eat a pureed diet of liver, mashed potatoes, greens and jello pudding from a high-sided plate with a plate guard that was on an elevated plateform. Cranberry juice, 1% milk and water was mixed with thick-it from a plastic tumbler. Client #1 was attempting to eat his food rapidly, however staff gave him verbal cues to slow his pace and the client complied. Interview with the Quality Assurance Specialist on June 29,	W 159 #4 W 159 #2	DC Health Care Staff was in-serviced on July 13, 2007 on documenting the food intake for Client # 1. The QMRP will monitor on a weekly basis and the QA will monitor quarterly. (See Attachment D)	07/13/07

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W 159	Continued From page 4 2007 at approximately 1:40 PM revealed that Client #1's fuild intake was being documented. Review of the Nutritional Assessment dated September 5, 2006 on June 29, 2007 at approximately 11:31AM revealed that Client #1 weighed 98.9 pounds, 12 pounds below his Ideal Body Weight (IBW) of 110-120. Further review revealed that Client #1's food intake should be monitored frequently. Review of the fluid/food intake log dated April 30, 2007 thru June 28, 2007 revealed that only Client #1's fluid intake was being monitored. There was no evidence that the client's food intake was being monitored as recommended by the nutritionist. 3. The Quality Assurance Specialist failed to ensure that all staff had been effectively trained to monitor/document the food intake of Client #2 as evidenced by: Dinner observation on June 28, 2007 at approximately 5:45 PM revealed that Client #2 was being fed by staff eat his prescribed 1800 calorie, high fiber, low fat, low cholesterol diet. Interview with the Quality Assurance Specialist on June 29, 2007 at approximately 1:50 PM revealed that Client #2's fuild intake was being documented. Review of the Nutritional Assessment dated September 5, 2006 on June 29, 2007 at approximately 12:00 PM revealed that Client #2 weighed 107 pounds (IBW 95-117) and that his food intake should be monitored frequently. Review of the fluid/food intake log dated March 31, 2007 thru June 29, 2007 revealed that only Client #2's fluid intake was being monitored. There was no evidence that the client's food intake was being monitored as recommended by the nutritionist.	W 159		
		Pg #5 W 159 #3	DC Health Care Staff was in-serviced on documenting the food intake of Client #2 on July 13, 2007. The QMRP will monitor on a weekly basis and the QA will monitor quarterly. (See Attachment D).	07/13/07
W 310	483.450(e)(1) DRUG USAGE	W 310		

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W 310	Continued From page 5 The facility must not use drugs in doses that interfere with the individual client's daily living activities. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medication administered for blood pressure management does not interfere with the daily living activities for one of three clients in the sample. (Client #3). The finding includes: Cross refer to W120. Observation of evening medication administration on June 28, 2007 at approximately 6:30PM revealed that Client #3 was administered Clonidine HCL 0.1mg by mouth for hypertension. Review of the medical assessment dated August 14, 2006 on June 29,2007 at approximately 1:40PM revealed that Client #3 has a diagnosis of hypertension and is prescribed Clonidine HCL 0.1mg by mouth for twice a day for blood pressure management. Interview with the License Practical Nurse (LPN) on June 28, 2007 at approximately 6:34 PM revealed that Client #3 is prescribed Clonidine HCL 0.1mg by mouth for hypertension twice a day and possible medication side effects included drowsiness, sedation and insomnia. Interview with the staff of the day program on June 28, 2007 at approximately 1:30 PM, revealed that Client #3 is not able to complete many of his janitorial training tasks because of his excessive sleepiness during the day. Interview with the QMRP on June 28, 2007 at approximately 7:30 PM revealed that she was made aware on June 1, 2007 by the day program staff that Client #3	W 310	Client # 3 has been scheduled for Renal appointment on 09/12/07 and Urology appointment on 07/25/07. At that point an evaluation will be made in reference to his current medication. (See attachment B & C).	

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W 310	Continued From page 6 had fallen asleep during training. Review of day program progress notes dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 1:55PM revealed entires on each day that Client #3 was observed sleeping and was unable to complete his training program. Further review of the Day Program Director's progress note dated June 5, 2007 on June 29, 2007 at approximately 11:30AM at the facility revealed " the days [Client #3] didn't perform a task was because he was either trying to sleep or a different task was performed". Review of Client #3's sleep logs dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 10:55AM revealed entires on each day that Client #3 goes to bed at 10:00 PM and is generally awake at 10:30 PM, 12:30AM, 2:30AM and 4:30AM. Interview with the Program Director on June 29, 2007 at approximately 10:59 AM revealed that Client #3, possibly was toileted during those hours at night. There was no documented evidence to substantiate that medication administered did not interfere with the clients' daily living activities.	W 310	QMRP met with day program staff on June 29, 2007 and July 12, 2007 to monitor Client # 3's progress in reference to his excessive sleeping. The day program agreed to add alternative vocational tasks, so that there is variety in activities, which will encourage him to be alert at all times. QMRP will continue to monitor the day program on a weekly basis. (See attachment A).	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: On June 28, 2007 at approximately 9:45AM review of fire drill records and interview with the Program Manager revealed that during the past	W 441		

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W 441	Continued From page 7 year, staff had not practiced exiting through all five egresess of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.	W 441 Pg # 8 W 441	DC Health Care staff was in-serviced on July 13, 2007 on holding evacuation drills under varied conditions and to utilize all egresses when exiting the facility. (See Attachment E).	

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I 000	INITIAL COMMENTS A recertification survey was conducted from June 28, 2007 thru June 29, 2007. The survey was initiated using the fundamental survey process; however, as a result of the review of unusual incident reports and interviews, it was decided to extend the survey process in the area of Client Protections. A random sample of three residents was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home and two day programs, and interviews with residents, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	I 000		
I 053	3502.11 MEAL SERVICE / DINING AREAS Each GHMRP shall provide adequate staff in dining rooms to direct self-help dining procedures and to assure that each resident receives enough food. This Statute is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for two of three clients in the sample. (Resident #1 and #2) The findings include: 1. The QMRP failed to ensure that all staff had been effectively trained to monitor/document the food intake of Resident #1 as evidenced by: Dinner observation on June 28, 2007 at approximately 5:45 PM revealed that Resident#1	I 053		

Gyney Stephen — TITLE President — (X6) DATE 7/17/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 053	Continued From page 1 was self- feeding with stand by assistance to hold a built-up spoon to eat a pureed diet of liver, mashed potatoes, greens and jello pudding from a high-sided plate with a plate guard that was on an elevated plateform. Cranberry juice, 1% milk and water was mixed with thick-it from a plastic tumbler. Resident #1 was attempting to eat his food rapidly, however staff gave him verbal cues to slow his pace and the resident complied. Interview with the Quality Assurance Specialist on June 29, 2007 at approximately 1:40 PM revealed that Resident #1's fuild intake was being documented. Review of the Nutritional Assessment dated September 5, 2006 on June 29, 2007 at approximately 11:31AM revealed that Resident #1 weighed 98.9 pounds, 12 pounds below his Ideal Body Weight (IBW) of 110-120. Further review revealed that Resident #1's food intake should be monitored frequently. Review of the fluid/food intake log dated April 30, 2007 thru June 28, 2007 revealed that only resident #1's fluid intake was being monitored. There was no evidence that the resident's food intake was being monitored as recommended by the nutritionist. 2. The Quality Assurance Specialist failed to ensure that all staff had been effectively trained to monitor/document the food intake of Resident #2 as evidenced by: Dinner observation on June 28, 2007 at approximately 5:45 PM revealed that Resident #2 was being fed by staff eat his prescribed 1800 calorie, high fiber, low fat, low cholesterol diet. Interview with the Quality Assurance Specialist on June 29, 2007 at approximately 1:50 PM revealed that Resident #2's fuild intake was being documented. Review of the Nutritional Assessment dated September 5, 2006 on June	I 053 1. 2.	DC Health Care Staff was in-serviced on July 13, 2007 on documenting the food intake for Client # 1. The QMRP will monitor on a weekly basis and the QA will monitor quarterly. (See Attachment D) DC Health Care Staff was in-serviced on documenting the food intake of Client #2 on July 13, 2007. The QMRP will monitor on a weekly basis and the QA will monitor quarterly. (See Attachment D).	07/13/07 07/13/07

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I 053	Continued From page 2 29, 2007 at approximately 12:00 PM revealed that Resident #2 weighed 107 pounds (IBW 95-117) and that his food intake should be monitored frequently. Review of the fluid/food intake log dated March 31, 2007 thru June 29, 2007 revealed that only Resident #2's fluid intake was being monitored. There was no evidence that the resident's food intake was being monitored as recommended by the nutritionist.	I 053		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medication administered for blood pressure management does not interfere with the daily living activities for one of three residents in the sample. (Resident #3). The finding includes: Cross refer to W120. Observation of evening medication administration on June 28, 2007 at approximately 6:30PM revealed that Resident #3 was administered Clonidine HCL 0.1mg by mouth for hypertension. Review of the medical assessment dated August 14, 2006 on June 29,2007 at approximately 1:40PM revealed that Resident #3 has a diagnosis of hypertension and is prescribed Clonidine HCL 0.1mg by mouth for twice a day for blood pressure management.	I 401		

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I 401	Continued From page 3 Interview with the License Practical Nurse (LPN) on June 28, 2007 at approximately 6:34 PM revealed that Resident #3 is prescribed Clonidine HCL 0.1mg by mouth for hypertension twice a day and possible medication side effects included drowsiness, sedation and insomnia. Interview with the staff of the day program on June 28, 2007 at approximately 1:30 PM, revealed that Resident #3 is not able to complete many of his janitorial training tasks because of his excessive sleepiness during the day. Interview with the QMRP on June 28, 2007 at approximately 7:30 PM revealed that she was made aware on June 1, 2007 by the day program staff that Resident #3 had fallen asleep during training. Review of day program progress notes dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 1:55PM revealed entires on each day that Resident #3 was observed sleeping and was unable to complete his training program. Further review of the Day Program Director's progress note dated June 5, 2007 on June 29, 2007 at approximately 11:30AM at the facility revealed " the days [Resident #3] didn't perform a task was because he was either trying to sleep or a different task was performed". Review of Resident #3's sleep logs dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 10:55AM revealed entires on each day that Resident #3 goes to bed at 10:00 PM and is generally awake at 10:30 PM, 12:30AM, 2:30AM and 4:30AM. Interview with the Program Director on June 29, 2007 at approximately 10:59 AM revealed that Resident #3, possibly was toileted during those hours at night. There was no documented evidence to substantiate that medication administered did not interfere with the resident' daily living activities.	I 401	A meeting is scheduled for July 24, 2007 with Client # 3's Inter-Disciplinary Team (IDT) to address the excessive sleeping at the day program and necessary program revisions will be made. Mean while, the day program agreed to add alternative vocational tasks to keep him alert. Client # 3 has been scheduled for Renal appointment on 09/12/07 and Urology appointment on 07/25/07. At that point an evaluation will be made in reference to his current medication. (See attachment B & C).	7/24/07 7/25/07 9/12/07

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I 454	Continued From page 4	I 454		
I 454	3521.9 HABILITATION AND TRAINING Each GHMRP, in addition to the above provisions, shall assist each resident in obtaining placement in an appropriate educational, employment, or daytime training program; Provided, that the placement shall be consistent with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for three of three clients in the sample. (Resident #1, Resident #2 and Resident #3) The findings include: 1.Cross refer to W120. The QMRP failed to inform Resident #3's Inter-Disciplinary Team (IDT) that he was sleeping excessively in the day program as evidenced by: Observation of evening medication administration on June 28, 2007 at approximately 6:30PM revealed that Resident #3 was administered Clonidine HCL 0.1mg by mouth for hypertension. Review of the medical assessment dated August 14, 2006 on June 29,2007 at approximately 1:40PM revealed that Resident #3 has a diagnosis of hypertension and is prescribed Clonidine HCL 0.1mg by mouth for twice a day for blood pressure management. Interview with the License Practical Nurse (LPN) on June 28, 2007 at approximately 6:34PM revealed that Client #3 is prescribed Clonidine HCL 0.1mg by mouth for hypertension twice a day and that one of the medications possible side effects is drowsiness. Interview with the staff of the day program on June 28, 2007 at approximately 1:30 PM,	I 454	A meeting is scheduled for July 24, 2007 with Client # 3's Inter-Disciplinary Team (IDT) to address the excessive sleeping at the day program and necessary program revisions will be made. Mean while, the day program agreed to add alternative vocational tasks to keep him alert. Client # 3 has been scheduled for Renal appointment on 09/12/07 and Urology appointment on 07/25/07. At that point an evaluation will be made in reference to his current medication. (See attachment B & C).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G172	A. BUILDING _____ B. WING _____	06/29/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	903 14TH STREET, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 454	Continued From page 5 revealed that Resident #3 is not often able to complete any of his janitorial training tasks because of his excessive sleepiness during the day. Further interview revealed that in early June, the facility's QMRP was verbally made aware that Resident #3 was sleeping excessively while at the day program. Interview with the QMRP on June 28, 2007 at approximately 7:30 PM revealed that she was made aware on June 1, 2007 by the day program staff that Resident #3 had fallen asleep during training. Further interview revealed that she did not make the IDT aware that Resident #3 was sleeping excessively at the day program and was unable to complete his janitorial training tasks. Review of day program progress notes dated May 1, 2007 thru May 31, 2007 on June 28, 2007 at approximately 1:55PM revealed entires on each day that Resident #3 was observed sleeping and was unable to complete his training program. Further review of the Day Program Director's progress note dated June 5, 2007 on June 29, 2007 at approximately 11:30AM at the facility revealed "the days [Resident #3] didn't perform a task was because he was either trying to sleep or a different task was performed". Review of Resident #3's sleep logs for the month of May on June 29, 2007 revealed that Resident #3 is generally awake at 10:30PM, 12:30AM, 2:30AM and 4:30AM. There was no evidence that the IDT was made aware that the client was sleeping excessively at the day program and was unable to complete his janitorial training tasks. 2. The QMRP failed to ensure that all staff had been effectively trained to monitor/document the food intake of Resident #1 as evidenced by: Dinner observation on June 28, 2007 at approximately 5:45 PM revealed that Resident#1	I 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 454	Continued From page 6 was self- feeding with stand by assistance to hold a built-up spoon to eat a pureed diet of liver, mashed potatoes, greens and jello pudding from a high-sided plate with a plate guard that was on an elevated plateform. Cranberry juice, 1% milk and water was mixed with thick-it from a plastic tumbler. Resident #1 was attempting to eat his food rapidly, however staff gave him verbal cues to slow his pace and the resident complied. Interview with the Quality Assurance Specialist on June 29, 2007 at approximately 1:40 PM revealed that Resident #1's fuild intake was being documented. Review of the Nutritional Assessment dated September 5, 2006 on June 29, 2007 at approximately 11:31AM revealed that Resident #1 weighed 98.9 pounds, 12 pounds below his Ideal Body Weight (IBW) of 110-120. Further review revealed that Resident #1's food intake should be monitored frequently. Review of the fluid/food intake log dated April 30, 2007 thru June 28, 2007 revealed that only resident #1's fluid intake was being monitored. There was no evidence that the resident's food intake was being monitored as recommended by the nutritionist. 3. The Quality Assurance Specialist failed to ensure that all staff had been effectively trained to monitor/document the food intake of Resident #2 as evidenced by: Dinner observation on June 28, 2007 at approximately 5:45 PM revealed that Resident #2 was being fed by staff eat his prescribed 1800 calorie, high fiber, low fat, low cholesterol diet. Interview with the Quality Assurance Specialist on June 29, 2007 at approximately 1:50 PM revealed that Resident #2's fuild intake was being documented. Review of the Nutritional Assessment dated September 5, 2006 on June	I 454 2. 3.	DC Health Care Staff was in-serviced on July 13, 2007 on documenting the food intake for Client # 1. The QMRP will monitor on a weekly basis and the QA will monitor quarterly. (See Attachment D) DC Health Care Staff was in-serviced on documenting the food intake of Client #2 on July 13, 2007. The QMRP will monitor on a weekly basis and the QA will monitor quarterly. (See Attachment D).	07/13/07 07/13/07